APPROVED PA Criteria

Initial Approval: July 9, 2008
Revised Dates: January 8, 2014
April 11, 2012
November 12, 2008

CRITERIA FOR PRIOR AUTHORIZATION

Cimzia ® (certolizumab pegol)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Certolizumab Pegol (Cimzia)

CRITERIA FOR CROHN'S DISEASE (CD): (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent tuberculosis (TB) with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional Crohn's disease therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional Crohn's disease therapy (see attached table)

CRITERIA FOR RHEUMATOID ARTHRITIS (RA): (must meet all of the following)

- Patient must have a diagnosis of rheumatoid arthritis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR PSORIATIC ARTHRITIS (PSA): (must meet all of the following)

- Patient must have a diagnosis of psoriatic arthritis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR ANKYLOSING SPONDYLITIS (AS): (must meet all of the following)

- Patient must have a diagnosis of ankylosing spondylitis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

LENGTH OF APPROVAL 6 months

Biologic Agents	
Generic Name	**Brand Name**
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Tofacitinib	Xeljanz®
Ustekinumab	Stelara®

Conventional Crohn's Disease Therapies	
Generic Name	**Brand Name**
Azathioprine	Azasan®, Imuran®
Budesonide	Entocort®
Cortisone	Cortone®
Dexamethasone	Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak®
Hydrocortisone	Hydrocortone®, Cortef®
Mercaptopurine	Purinethol®
Mesalamine	Apriso®, Lialda®, Cariasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa®
Methotrexate	Trexall®, Rheumatrex®
Methylprednisone	Medrol®, MethylPred®, Meprolone UniPak®
Prednisolone	Prelone®, MilliPred®, OraPred®, VeriPred®, Bubbli-Pred®, PediaPred®
Prednisolone/Peak Flow Meter	AsmaPred Plus®
Prednisone	Orasone®, Meticorten®, SteraPred®, Deltasone®, Prenicen-M®
Sulfasalazine	Azulfidine®, Sulfazine®